WORKING TOGETHER FOR MENTAL HEALTH:
A Proposed Mental Health Services Strategy for Newfoundland and Labrador

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Introduction and Context

The Need

In the mid 1990s, the government of Newfoundland and Labrador recognized the need for strategic social planning. The many demands on human services in the face of tremendous change and challenge required a blueprint for reform and for the future. The strategic social plan led the way for *Valuing Mental Health: A Framework to Support the Development of Provincial Mental Health Policy for Newfoundland Labrador (2001)*. The process involved was inclusive, based on the views, effort and collective best wisdom of more than 100 individuals and organizations that provided input. This framework endorsed a mental health strategy within the province and provided the values, vision, principles, goals and objectives to achieve it.

Healthier Together (2002), a strategic health plan for Newfoundland and Labrador, identified the mental health system as a priority area for development and enhancement. It states that "... the existing level of services is underdeveloped despite the creation of community mental health since the mid 1990s. It is the lack of community-based services that is most obvious." Furthermore, the *Review of the Community Mental Health System (2002)* which reviewed the mental health service system in Newfoundland and Labrador, determined that "... the existing mental health system is institutionally-based ... services are fragmented and disconnected ... there is limited consumer involvement and families have few supports" (Executive Summary). Addictions services were not included in the terms of reference for this review. Yet, we know there are issues with the continuum of addictions services that need to be addressed. Clearly, a strategy for mental health and addictions services is needed for Newfoundland and Labrador.

The Scope and Aim of the Strategy

Working Together for Mental Health will be based on the goals outlined in *Valuing Mental Health (2001)* and reaffirmed in *Healthier Together (2002)*. The scope of this strategy will cover the full continuum of mental health services, which includes psychiatric and addictions services. Building a comprehensive system of primary

mental health and specialized services will be the focus. *Working Together for Mental Health* will be developed from a people-centered perspective and will have as its major aim, improvements in the mental health status of those who use mental health and addictions services, as well as the broader general population.

Working Together for Mental Health takes its name from three ways that we will be working together. We have not completed a provincial plan for mental health/addictions services before and are now working together in all regions to ensure this strategy will strengthen services for consumers, families and communities. Secondly, the mental health system will work very closely with: (I) the emerging primary health care teams to ensure a solid foundation for primary mental health care; (ii) the wellness strategy, which will recommend mental health promotion initiatives for the province; and (iii) the long-term care and supportive services strategy, which will address models of care, including housing and home support, for individuals requiring long term supportive care. Thirdly, a critical component for a successful strategy will be collaborative shared mental health and addictions care between primary mental health care services, specialized addictions/mental health services and consumers, families and communities, that is, working *together* for mental health.

There will be processes identified for accessing all levels of service and the strategy will account for regional and geographic variation as well as current and future demographic realities. *Working Together for Mental Health* will also address all age groups, and as such, will develop specific action plans for the children and youth of our province, as well as our seniors. This will be undertaken with consumers and family members being central to the process.

It is envisioned that when completed, *Working Together for Mental Health* will include an overall plan for mental health/addictions services for the province; an implementation plan, which will identify resources that are available as well as outstanding resources needed to implement the plan; and an evaluation plan, complete with indicators, for the long-term management and continuing improvement of the system.

The Policy Framework

There has been an international movement to promote mental health, prevent mental health problems and mental illness and lessen the global burden of mental ill health. The World Health Organization produced *Primary Prevention of Mental, Neurological and Psychosocial Disorders (1998)* and terms such as "early intervention" and "prevention" have become mainstream in the mental health literature, even when referring to psychosis. Australia released its national mental health strategy in 2000 and is now releasing a national mental health plan to provide direction for the next five years. These plans, as well as those released in the U.K. (1999), New Zealand (1997) and the U.S. (2003) are focused on improving the mental health status within communities and ensuring responsive systems which involve consumers and families.

Integrating mental health and addictions services provides a more connected framework. In the 1960s and early 70s, persons with alcohol addiction were treated separately from those with drug addiction. Persons with mental illness were institutionalized. However, currently these three "clinical" populations live in the community with overlapping substance abuse and mental health problems. Linkages should be strengthened between primary health services, mental health services and addictions services, so that the needs of individuals, families and communities will be examined within a larger, more holistic context.

Within Canada recognition has been given through the Kirby (2002) and Romanow (2002) reports that mental health services need strengthening. Primary health care renewal has been occurring in every province and territory with federal funding provided to support the transition to primary health care. There has been a proliferation of shared mental health care arrangements between family doctors, psychiatrists and mental health/addictions counselors and evaluations (Kates and Ackerman, 2002; Malcolm, 2000; Kates, 1999) show there are benefits for consumers and families, as well as service providers, from more effective collaboration. As a result, many provinces are strengthening these links.

The timing of the primary health care renewal in Newfoundland and Labrador couldn't be more opportune for a comprehensive mental health strategy. Ensuring this strategy is grounded in primary health care will place services in the best possible position to meet mental health needs and will assist Newfoundlanders and Labradorians to improve their mental health.

Strategic Direction 1

Enhance Mental Health Promotion and Prevention

Real change in the mental health status of the people of our province will happen only when our society takes responsibility for preventing addiction and mental ill health and promoting good mental health. Our mental health and addictions system has to focus on promotion and prevention actions. Mental health promotion is most effective when interventions build on social networks, promote and support community capacity building and use a combination of methods to strengthen (I) individuals to enhance their own mental well being and (ii) communities in addressing the local issues which challenge mental health.

1.1 To promote good mental health and prevent mental health problems and addictions through universal health promotion activities. These activities may include but are not limited to:

A. Supporting the enhancement of the capacity of individuals, families and communities to take control of their lives and improve their mental health.
   - Link with the Wellness Strategy in achieving measurable outcomes in the reduction of risk factors to poor mental health.

B. Combating discrimination and social exclusion through
   - Anti stigma campaigns and programs for communities
   - Education and awareness activities in schools
   - Ensuring affordable, appropriate housing.
   - Addressing stigma in the workplace through education, awareness and policy development that promotes inclusion.

C. Developing and/or strengthening existing programs for vulnerable groups such as:
   - Survivors of child abuse and domestic violence
   - People in Prison
   - People with alcohol and drug problems

D. Enhancing support for parents during pregnancy and after birth with home visits, high quality child care and helping through schools and community networks.
   - The development, ongoing support and evaluation of programs such as *Healthy Baby Club, Bright Futures* and *Healthy Beginnings* should be encouraged.

E. Programs within schools and community groups on reducing access to illicit drugs, taking alcohol in moderation, reducing smoking and the effects of drugs and alcohol on adolescents, expectant mothers and seniors should be developed in areas where not available and strengthened and supported wherever they are offered.

F. Preventing suicide by:
   - Promoting awareness of the factors which increase risk of suicide
   - Providing public education and awareness on signs, symptoms of suicidal intent and how to provide/access help.

G. Partnering with Education, Justice and Human Resources and Employment sectors to ensure consistent policy development regarding issues that impact on mental health.

Questions: What other specific actions are required to promote and improve good mental health?

Strategic Direction 2

Provide clinical services needed by individuals with mental illness, mental health problems and addictions at a time and in a way that is appropriate to their situation.

2.1 Incorporate primary mental health care services as a key component of primary health care teams in each region as follows:

A. Community mental health clinicians and addictions counselors should join primary health care teams as they are established throughout the province.

- As primary health care teams are established and local population needs are determined, mental health clinicians and addictions counselors should join teams along with other health care providers. *Moving Forward Together: Mobilizing Primary Health Care (2003)* outlines a complete description of the features of primary health care renewal.
- This will include primary mental health and addictions services for all ages from children to seniors.
- A proposed staffing standard for mental health clinicians should be one FTE per 6 - 7,000 population. (This does not include case managers or addictions counselors.)
- The Hamilton-Wentworth project used 1 FTE per 6 - 7,000 (Kates,1999); New Zealand: 110 staff per 200,000. Standards are still needed to determine the appropriate FTEs for addictions counselors.
- These clinicians may be mental health nurses, nurse practitioners, social workers, psychologists or occupational therapists with experience working in mental health and addictions settings. The role of these clinicians will include responsibility for:
  - The mental health of the population to be served.
  - Screening/identification of individuals/families vulnerable for mental health problems and addiction.

- Targeted interventions, including community workshops and group sessions.
- Partnering with local groups regarding early intervention strategies
- Assessment/treatment and follow up of individuals with mental illness and/or an addiction.
- Large consultative/linkage role with specialized psychiatric mental health services
- Evaluation of effectiveness on population mental health and specific client groups within 2-3 years

Question: What specific issues should be addressed to assist staff in transitioning to primary health care teams? What best practices can be identified to ensure interdisciplinary teams are effective?

B. A mobile crisis response for mental health emergencies should be accessible by each primary health care team.

- Each team should ensure emergency transportation for individuals who require it. This would include mental health emergencies.
- Each team/region will need to decide whether a team member accompanies the ambulance, or if another crisis response besides ambulance and mental health staff is necessary.
- Effective protocols, based on best practice, will need to be developed.

C. Case Managers to be determined for each region and assigned to primary health care teams.

Case managers coordinate the care and treatment for persons with mental illness. A case manager is indicated when a person could benefit from having someone assist them, either with helping them to get back to work or school; ensuring all involved in their care, such as family, medical staff,

home support workers, income support staff and others, are kept informed and have ongoing communication; or with providing direct care, such as teaching about symptoms or medications, assisting with developing life skills, and support.

- Case managers have similar backgrounds as mental health clinicians and will also have experience working in mental health settings, particularly with persons with mental illness or concurrent disorders (mental illness and physical disease or mental illness and addiction).
- Roles of case managers should include responsibility within primary health care teams for: individuals with mental illness who require support and assistance with coordinating care; supportive counseling; home visits; linkages with family/client and primary health care team and other services; client specific interventions such as coordinating home care, arranging transportation or administering medication.
- Assertive case management, which involves close follow up and monitoring may be more appropriate for the very few individuals with severe persistent mental illness and a history of little engagement with the mental health system.
- Case manager staffing ratios will depend on the needs of the population. Standards that may be used are 10 clients per case manager for assertive community treatment and 30 clients per case manager for rehabilitative/ recovery approaches. These standards are based on current literature and best practice.

D. Home support should be available for individuals with severe mental illness who require some supportive services at home in order to maintain functioning within the community.

- There is some access to home support for children and youth under child, youth and family services program. As well, there is some home support available for seniors with mental illness. However, access is currently limited and should be available to adults as well.

E. Psychiatrists should enter into shared care arrangements with primary health care physicians which should facilitate support for primary mental health care and better care for consumers and their families.

- Psychiatrists and family physicians (particularly those involved in primary health care renewal) in all regions should work together to discuss roles and responsibilities and determine how best to support each other in providing primary mental health care.
- Primary mental health care addresses many concerns that plague traditional mental health systems, however, it is not a panacea. Many Canadian, U.K. and Australian studies tell us that primary mental health care works well when it is based on good communication, mutual respect between generalists and specialists and efforts are made at relationship building. No one model fits all and therefore, it is critical that family physicians and other primary health care team members throughout the province meet and decide which arrangements work best for them.

Questions: What training requirements will case managers, mental health clinicians and addictions counselors need in order to work comfortably and confidently in primary health care teams? What specific actions are required to support psychiatrist involvement in primary health care teams? How do we assist primary health care teams in creating a comfortable and accepting environment to care for all individuals with mental ill health and addictions in their communities?

System Integration

The "Review of the Community Mental Health System" (2002) described a disconnect between community-based and institutional mental health services. While partnerships exist, linkages are not consistently strong within mental health services and traditionally have been weak with other health care services such as primary health care and addictions. In other jurisdictions, addictions services have been aligned with mental health services and have found new opportunities for improving access and

responsiveness. Both addictions counselors and community mental health counselors will become part of primary health care teams, which will not only link their services but also will link them with primary health care services.

The vehicle that will link these services with specialized services will be mental health/ addictions interdisciplinary teams. These teams will be linked with hospitals where dedicated mental health units exist. They will bridge the continuum between primary mental health and addictions care and inpatient/outpatient specialized services. These teams will be connected with inpatient units and treatment centers but will not be dedicated inpatient staff and will have as their focus, a linkage of shared care with the primary health care teams in their areas.

These teams should provide services for a determined number of primary health care teams. They will link with those teams and share the care, where necessary, for persons with mental illness or an addiction. This will ensure that, in the event an individual requires an inpatient admission, that the inpatient care and follow up with the primary health care team is as seamless as possible. They may also provide specialized services for the area such as mobile crisis response and/or case management.

2.2 **Establish a continuum of specialized mental health services accessible by each region and based on best practices. These services should include the following:**

A. Case Management/Assertive Community Treatment

Assertive community treatment is a team treatment approach designed to provide comprehensive, community-based mental health treatment, rehabilitation and support to persons with severe and persistent mental illness. Persons served by assertive community treatment are individuals with severe and persistent mental illness or personality disorder, with severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care. These individuals often have co-existing problems such as substandard housing, substance abuse problems and/or involvement with the judicial system.

Assertive Community Treatment should be available for those who may have become marginalized in their communities due to the symptoms of their illness and their subsequent behaviors. Persons living with psychosis and other long term mental illnesses may refuse to take medication and also refuse interventions by mental health counselors. Their behavior may be odd, particularly if they are responding to hallucinations and they may be fearful or suspicious of others. As a result, their activities of daily living are impacted. They may not socialize well, take care of their personal hygiene or their surroundings. Families may be very worried and concerned but unable to help, particularly if their loved one is refusing help. Communities may be concerned for the individual, but unable to activate help. Too often the police are the only ones left to intervene. The mental health system should be more responsive to the needs of these individuals, families and communities. Assertive community treatment is an evidence based best practice that has had positive outcomes in other jurisdictions (Davidson, 1999; Lang et al, 1999) and should be part of the continuum of mental health services in this province.

- May be delivered from primary health care teams or in specialized service settings.
- Assertive community treatment is provided in teams of assertive case managers. The principles of assertive case management may need to be adapted within primary health care teams or in urban centers they may be specialized assertive community treatment (ACT) teams.
- Principles for assertive community treatment should be adopted, including assertive outreach, low client-staff ratio, locus of contact in the community and ready access in times of crisis.
- Case managers will require the support of whichever team they are part of with respect to coverage, relief and sharing responsibility for follow up, particularly for individuals who may be unable, due to their illness, to willingly accept treatment.

- Case management may be offered in combination with other services such as mobile crisis response.
- Services should be organized in the most efficient way(s) possible with some current resources being redeployed.

B. Crisis Response/Emergency Services

- Primary health care teams should provide 24-hour emergency services for their population.
- In addition to a mental health crisis line each region requires access to community-based crisis beds.
- The use of lock ups to detain individuals under the Mental Health Act, purely for detention purposes should be eliminated.
- Police intervention in mobile response should be limited to situations with predetermined criteria such as barricading, weapons or hostage takings. Crisis response is a mental health service and should be coordinated by health care staff.

Questions: What needs to happen within your region to create a safe, effective, mobile crisis response? How do we ensure a safe and comfortable environment for consumers detained under the Mental Health Act is not a correctional facility? What indicators should be identified to measure improved outcomes?

C. Acute Inpatient Mental Health/Addictions Treatment

This includes acute care mental health beds as well as acute residential treatment centers. By February 2004 there will be 163 acute care mental health beds in the province which translates to 31 acute mental health beds per 100,000 population. It includes geriatric assessment beds as well as child mental health beds, but does not include long term psychiatric rehab, geriatric or forensic beds. Other provinces (Alberta: 26/100,000; Ontario 21/100,000; British Columbia 27/100,000) are roughly equivalent. There are 41 beds for addictions between Humberwood on the West Coast and the Recovery Center in St. John's.

- Inpatient treatment should be reserved for those who require hospitalization in order to recover.
- Principle of treatment in the least restrictive setting should be followed and inpatient stays kept to a minimum.
- Benchmarks established through Canadian Institute for Health Information (CIHI) should be part of an overall utilization management plan for efficient use of beds.
- Model of acute care inpatient mental health services needs to be developed that identifies:
    - reasons for admission
    - services to be provided
    - expected outcomes
- Model of acute inpatient care to be discussed with community and consumer groups so that all recognize the role hospitalization plays, i.e., a brief but necessary acute intervention with a quick return to community.
- All inpatient mental health units should be designed to admit involuntary clients under the Mental Health Act.
- Best Practice guidelines are available for managing violent behaviour which continue the use of risk assessment, anger management techniques, verbal de-escalation, medication and finally seclusion only if absolutely necessary. International trends in managing disturbed behaviour are moving toward restraint-free environments with a focus on preventative measures.

Questions: Under what circumstances should a person be admitted to either an addictions center or an acute mental health unit? What needs to happen to ensure a safe, secure therapeutic milieu within these environments?

D. Acute Community Mental Health Care

Other alternatives to inpatient stays should be addressed and include:

- Acute mental health home care (currently being explored by F/P/T Working Group on Home Care Basket of Services).

- Home support service: A reasonable program of home support for those with mental illness is needed on a regional basis and should be organized by long-term care and supportive services strategy.
- Home support may be the most important component of care for individuals.
- Substitutes for hospitalization should be considered such as day hospitals.
- Supportive housing, while not an alternative to inpatient stay, should be considered when developing acute care alternatives to ensure success.
- Processes for quick access to outpatient mental health services on an urgent basis need to be considered.
- Acute community mental health services should be geared toward early intervention. In particular, access to early interventions with first episode psychosis should be available. Ways of linking with the St. John's based Early Psychosis Program are being explored and should be supported.

Question: How do we shift our focus from hospitalization to other alternatives and gain acceptance?

E. Vocational/Educational Supports

When mental illness or an addiction occurs, job, education, and leisure/ recreation activities are often negatively impacted. Services in these areas which assist the client in regaining these activities are critical for facilitating recovery and promoting well being.

- Appropriate linkages between mental health services, Human Resources and Employment and the Education sectors need to be strengthened to ensure consumers and families have access to all services that may be available to them, such as financial support for transportation, medication; adequate housing; employment readiness programs; access to programs for re entry to school; supported Adult Basic Education.
- Coordinating services for a seamless delivery

- Community-based occupational therapy and recreation therapy services need to be enhanced.
- Continuum of services from leisure and recreation to employment readiness and supported employment should be in place. This should include the feasibility of club houses.
- Options for financial support, in the form of Scholarship Funds for consumers should be fully explored. Currently linkages with post secondary institutions need to be strengthened and information shared so that consumers/families can access information readily on all available supports for returning or beginning school.

Questions: How do we maximize the expertise of recreation specialists and occupational therapists in the community? How can we ensure people with mental illness and/or an addiction have access to information regarding all available supports/services for getting back to school/workforce?

F. Forensic Services:

There are currently about 25 individuals in Newfoundland and Labrador who have been charged with an offence and subsequently found *not criminally responsible due to a mental disorder*. Some are being treated at the Waterford Site of the Health Care Corporation of St. John's, but others are living in their home communities. There is no coordinated follow up for these individuals, other than psychiatric outpatient appointments. These individuals, who usually suffer from severe and persistent mental illness, require psychiatric and mental health care follow- up.

- A dedicated case manager should be provided to connect with these clients, liaise with the review board, the clients' psychiatrist, the families, as well as primary health care teams to ensure these clients are receiving the supportive services they need.

G. Seniors Mental Health Services

Current service delivery models do not reflect the complex and changing mental health needs of seniors. Mental health and behavioral problems associated with senior's mental illness are not a natural part of aging and

much can be done to prevent deterioration, restore health and enhance quality of life.

Seniors are at high risk of suffering from dementia or delirium, along with the full range of mental illnesses which affect the general population. Seniors are impacted by ageism and stigma when seeking out services. Supports to informal caregivers and family members are totally inadequate, in spite of the huge economic value provided by them. In nursing homes, where it is estimated that as high as 90% of the population has a mental illness, behavioral and psychological symptoms of dementia create challenges for staff and other residents (Brodaty, Draper and Low, 2003). Home support is lacking and could potentially be the biggest predictor of whether a senior is admitted to an institution or able to stay at home.

- Primary health care teams should provide mental health care to seniors in their communities. Nursing homes should receive services from primary health care teams in their area.
- A specific action plan for seniors' mental health services will be developed through a province-wide expert think tank session. Participants will be sought from consumers and families, front-line service providers, community representatives and policy makers.

Question: What community supports should be available to seniors with mental health problems?

H. Child and Adolescent Mental Health Services

It is consistently identified that one child in five suffers from a mental health or substance abuse disorder, yet research demonstrates that the majority of children are not receiving effective and appropriate treatment An Ontario Child Health Study revealed that only one in six of the 18.1% of children with a psychiatric disorder was seen by one or both of child welfare or mental health services.

The Newfoundland and Labrador model for Coordination of Services for Children and Youth is a process already in place for children with special needs. Partnerships with the Wellness Strategy and Primary Health Care Renewal will be critical to ensuring effective mental health promotion and prevention strategies are in place for children and adolescents. More will be needed to ensure a comprehensive strategy is in place that is responsive to children, youth and family needs.

- Similar to seniors mental health and addictions services, a specific action plan for child and adolescent mental health and addictions services will be developed through a province-wide expert think tank session.

Question: What specific early intervention strategies are needed to address the mental health needs of children and youth of our province?

I. **Services for Aboriginal Peoples**

Despite separation of federal and provincial health funding for First Nations peoples, there is a need for access to provincial mental health services, particularly in Labrador. The complexities involved in delivering these services appropriately, including geographic, cultural and language barriers, require planning in partnership with First Nations peoples.

J. **Specialized mental health services**

Throughout the rest of Canada, mental health services have seen dramatic change with the shift from institutional services to community-based services and the movement toward integration of services. Concurrent with this has been the downsizing/closing of some provincial psychiatric hospitals and the enhancement of specialized services at the remaining facilities. A shift for acute care mental health services has also occurred with the main-streaming of acute care mental health into general hospitals.

- A specific action plan should be developed which will outline steps for strengthening regional mental health acute care inpatient services as well as a plan for strengthening and enhancing provincial specialized mental health services. This will be undertaken as a province wide expert think tank session.

Strategic Direction 3

Ensure smooth connection/linkages to other community services and supports that people need to recover, improve and maintain their mental health.

Mental health and addictions services must be well coordinated, integrated and should be "seamless" to consumers and families when accessing services.

3.1 Work closely with ongoing initiatives within other strategies of *Healthier Together (2002)*.

A. Create linkages and cross representation to ensure good communication between all strategies on a local, regional, provincial and national level.

3.2 Ensure planning for and implementation of services involves all stakeholders.

- Collaborate with community, consumers and families, as well as other service areas such as Education, Justice, Human Resources and Employment, ensuring the involvement results in improved service delivery from the consumer's perspective.

3.3 Partnerships with groups such as Canadian Mental Health Association, Schizophrenia Society of Newfoundland and Labrador, CHANNAL, and other local, regional groups should be strengthened so that services are planned and evaluated collaboratively.

- To support consumer initiatives to remove barriers and address stigma and mis-perceptions about people who live with mental illness. These initiatives might include:
  - Promoting self help as an effective, inexpensive adjunct and occasionally, an alternative to many clinical interventions. Primary health care teams and to some extent, specialized interdisciplinary mental health/addictions teams should cooperate with consumer groups to exchange and enhance self help capacity and expertise for all who choose it. This should not be limited to mental illness-based self help but all types of self-help which may be viewed as part of mental health promotion.

Strategic Direction 4

Ensure the involvement of the individual and significant caregivers (family or friends) in planning and decision-making with their own care and treatment as well as on a system-wide level.

4.1 Consumer Initiatives:

The person/family accessing services should always be the central focus of any service delivery. Consumer knowledge, expertise and leadership is a key component of mental health systems. Consumer involvement ensures accountability, patient satisfaction and capitalizes on the value of experiential knowledge. The term *Consumer*, rather than *patient* is used, to reflect an active role in personal care, to reflect the right to choice of services, the right to complain if a service is not adequate and the right to be consulted when new services are being designed, implemented and evaluated. Groups such as the Consumer Health Awareness Network of Newfoundland and Labrador

(CHANNAL) and the Schizophrenia Society of Newfoundland and Labrador (SSNL) operate self-help support groups and have been active voices for change and progress in the delivery of mental health services in Newfoundland and Labrador.

- To provide in kind, and where possible, financial support for self-help initiatives, individual and family advocacy, consultation to decision makers as well as education to professionals, families, students and most importantly, other consumers.
- To support consumers' involvement to complete evaluations of the services they receive and communicate the findings.
- To provide consumer education, at the earliest opportunity, within primary health care and specialized interdisciplinary mental health/addictions teams to ensure the person with mental illness or an addiction has the knowledge to facilitate personal recovery.
- To encourage effective self-help innovations such as a web-based support service or a phone-in group meeting via teleconference that could link consumers on a regular basis across the region or province. This would facilitate sharing of ideas in a confidential manner and would diminish stigma.

Question: How do we ensure consumers become active participants in their own care and in system issues? What supports are required to sustain appropriate consumer involvement?

4.2 Family Support

Family members (who may be parents, spouses, siblings, partners or close friends) provide more care and support for individuals with mental illness than the entire mental health system. However, they receive very little support themselves in doing so, to the extent that their own mental well-being is often jeopardized. Current protocols may exclude family members from receiving information about care and treatment on the grounds of confidentiality, and even when they share a home with their ill family member, they are seldom included in planning as part of the team.

Approaches within the Mental Health Strategy should include:

- Educational opportunities for family members on the relevant mental illnesses;
- Sensitive communication with family caregivers that both recognizes their role and respects the privacy of the consumer;
- Inclusion of family caregivers as members of the primary mental health care team;
- Support to families in developing and maintaining mutual support groups;
- Where local support groups do not exist, referral to the provincial family support telephone network (currently being planned).

Question: What processes need to be in place regarding consent, privacy and what practices need to change to ensure families/caregivers are included and supported? What role can families play in developing early intervention strategies?

Strategic Direction 5

Make the most effective, flexible use of available resources.

Mental health systems, in comparison to other health specialties, do not rely on high technology to provide services. Rather, the greatest resource within mental health services is the people who choose to work there; the counselor, physician or support worker who can and often does, make a difference in the lives of consumers and families.

A significant component of implementing *Working Together For Mental Health* will be the considerable effect on mental health service providers, including clinicians, managers, physicians and support staff. It is expected that more human resources will be required in some areas. In others, current staff may be redeployed. Communicating and involving staff in the change should assist in alleviating staff anxiety, although it has

to be recognized that these changes invariably cause distress. While the process allows for considerable consultation, planning the actual change and involving staff will be critical to ensuring that the staff who work in mental health and addictions services are able to maintain their high commitment and dedication to the services and those that use them.

5.1 Identify where all existing mental health human resources will best fit in a reorganized system.

- Primary health care teams
- Mental health interdisciplinary teams
- Other specialized services
- Target resources to the greatest need and where the greatest impact may be made.
- Ensure equitable access to resources across region, based on population need.

5.2 Identify human resource requirements to implement the mental health strategy within regions.

- Based on the needs of individuals, families and communities, identify the best mix of clinicians to provide services to meet those needs.
- Strategic Direction 2: *Provide clinical services needed by individuals with mental illness, mental health problems and addictions at a time and in a way that is appropriate to their situation* should form the foundation for decisions on skill mix. As well, available information should be reviewed on human resource issues including, but not limited to: scope of practice; recruitment and retention; information on current supply and gaps; education, licensure and training; and advanced practice.

5.3 Identify staff needs within the strategy and develop processes for meeting them wherever possible.

- There should be provision to provide, in conjunction with Department of Health and Community Services, a two day workshop on the final, approved mental health strategy. This workshop should include detailed

explanation of the strategy as well as topics such as primary mental health care; working in interdisciplinary teams; new roles for consumers and integrating families in teams; best practices and integration of mental health and addictions services.

- The importance of specific training and orientation to new workplaces, new processes and new roles cannot be overestimated. Staff should be included in the development of training and orientation packages and all professional development, training sessions and orientations should be evaluated by the staff who complete them.

Strategic Direction 6

Ensure accountability of the system to the consumer and the public.

6.1 Establish a provincial indicator framework that includes:

- Client outcomes, using valid, reliable instruments that are approved by consumers and measure changes in symptoms and quality of life.
- Measurements of the eight domains of health system performance: acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency and safety.
- "Accountability and Performance Indicators for Mental Health Services and Supports" (F/P/T Advisory Network on Mental Health) as a guide.
- A consumer/family developed scorecard. This scorecard would be developed, approved and implemented by consumers and families and used in regions on a regular basis to assess performance. Results should be discussed with all stakeholders and areas for improvement outlined.

Question: Which indicators are priority within the eight domains of health system performance?

6.2 **Adopt the fourth edition, revised version of the Diagnostic and Statistical Manual for Mental Disorders (DSM IV-R), all axes, to promote communication between service providers and consumers/families.**

DSM IV is the Diagnostic and Statistical Manual used by medical staff and mental health clinicians for providing descriptive and diagnostic information. It is the main tool used by physicians for diagnosing mental illness and is based on clusters of symptoms which fulfill criteria for different disorders. Diagnosis of a mental illness is the first axis, or area where one can provide information regarding a client. There are four other areas, or axes, which provide information, as follows:

Axis 2: Personality features
Axis 3: Medical diagnosis, for example, diabetes
Axis 4: Psycho-social stressors
Axis 5: Global Assessment of functioning

The DSM IV is used internationally and is the most often used diagnostic tool for research. It would be of great benefit to service providers, families and consumers to be able to communicate with each other using the same information and language. As well, the DSM IV can assist in tracking change in a person's status over time, particularly as life stressors, medical condition, or overall functioning changes.

The DSM IV should be used within primary mental health care teams, inter-disciplinary mental health and addictions teams and wherever mental health/ addictions service providers are working with consumers and families.

- Provide training in DSM IV where needed.
- Promote the use of the multi-axial system, especially axes three to five which will provide critical information on psycho-social stressors, concurrent medical conditions and global assessment of functioning.

6.3 **Create Province-Wide Profile for Mental Health**

Mental health is about more than just mental illness, or addictions. The mental health of a population is directly and powerfully linked to that society's economic, education, employment and social status, yet, psychiatric care alone accounts for

16% of direct health care costs. Mental illnesses often co occur with addictions and with chronic illnesses such as coronary artery disease, cancer, diabetes, HIV/AIDS and stroke. This is a significant amplifier of health care costs.

International studies have identified that mental illness, mental health problems and addictions are far more prevalent and responsible for much more disease burden that previously thought. By the year 2020, mental illness will account for 15% of the disease burden world wide, with depression a leading cause of disease burden, second only to ischemic heart disease. This presents a 50% increase in the prevalence of neuropsychiatric disorders. Since 1990, mental illness has accounted for almost 23% of the burden of disease in established market economies. (Andrews, 2000).

A significant unmet mental health need exists. About 20% of the population suffers from a mental disorder, yet only 32 % of those sought treatment in Canada in the previous 12 months (Statistics Canada, 2003).

- A structure is needed for mental health provincially that operates within a regional board structure, yet gives mental health the profile it needs to address issues provincially.
- Leadership is needed throughout the system, including government, boards, communities, consumers and within the network of direct service providers. Beginning with government, leadership across the province needs to be encouraged and mentored.
- Innovation and research need strengthening, with networks of interested stakeholders being developed.

System-Wide Issues

Legislative Considerations

The *Mental Health Act* is a difficult and controversial piece of legislation. It is the framework upon which decisions can lawfully be made on behalf of those who, because of reasons of severe mental illness, are unable to make decisions for themselves and is the only legislative authority, apart from the criminal code and related statutes, which permits detaining individuals against their will.

The age of the current Act (30 years) reflects a time when patient rights were not a paramount issue in the health system. Thus, the legislation is weak on the protections afforded to individuals detained by the Act. Secondly, the act is outdated in terms of developments in the practice of psychiatry and out of step with current mental health systems in other comparable jurisdictions. It no longer reflects the reality of mental health practice. Without question, there is a pressing need to design and implement a new *Mental Health Act* which will reflect current knowledge and clinical practices while respecting the individual's autonomy and decision making power. An overhaul of the current legislation is a necessary step within a comprehensive mental health strategy.

Proposed policy directions on (I) Basic Rights and Responsibilities, (ii) Expanded Clinical Provisions or Powers and (iii) Other Directions, such as Education and Information Management have been proposed by a Mental Health Legislation Stakeholder Committee.

Telehealth

Telehealth technology has been proposed as a means to provide mental health training and consultation to physicians and mental health staff as well as provide direct services to consumers and their families, in rural areas. This province has a well-developed telehealth system that is continuously improving. It includes both video and audio conferencing and has been used for child and adult mental health consultations, including assessments of individuals in remote areas via video conference, for certifiability under the Mental Health Act. Yet, there continue to be issues with using the system and widespread use has not occurred within mental health. Geography prevents accessibility to services in several areas of our province, yet accessibility has to be achieved. Comfort level with the technology and variable quality of the video transmission appear to be issues (Cornish et. Al, 2003) which should improve with more use. Telehealth is a vital part of shared care and a critical link in ensuring primary mental health care services are connected to specialized services throughout the province.

Conclusion

Mental health reform has been occurring in most provinces and territories since the early 1990s. The principles of community based mental health care; providing treatment in the least restrictive setting; and creating continuums of service based on best practices to meet needs have been accepted and followed wherever possible. However, it is becoming increasingly evident that traditional mental health systems have problems with accessibility and are not tapping into the unmet needs of populations.

Working together for mental health takes on new meaning in the context of implementing these strategic directions.

The time has come for consumers, families and communities to work together with service providers to ensure the best possible mental health strategy is developed for our province and by doing so, improve the mental health of the people of Newfoundland and Labrador.

FEEDBACK REQUEST

We encourage you to provide feedback on the development of the provincial mental health services strategy - Working Together for Mental Health. If you wish additional background information, please review _____ on the Department's website - http://www.gov.nl.ca/health. Please respond by _____, 2003.

Write us: *using regular mail,*	Working Together for Mental Health Department of Health and Community Services P.O. Box 8700 St. John's NL A1B 4J6
Phone:	1-877-929-0033
E-mail:	MentalHealthStrategy@gov.nl.ca
Fax:	(709) 729-3416
Visit our web site:	http://www.gov.nl.ca/health

General Information:

Gender: ❑ Male ❑ Female

Who are you? ❑ General Public ❑ Advocacy Group ❑ Union ❑ Employer ❑ Other (please specify) _____

Age: ❑ 18-24 ❑ 25-34 ❑ 35-44 ❑ 45-64 ❑ 65+

Questions to facilitate feedback

1. Do you think the changes described in this paper will improve mental health and addictions services in your community? Why or why not?
2. What difficulties might these changes create?
3. What do you think is missing from this plan?
4. If there was some money to support this plan in your region, where do you think the money would be best spent?

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